

Preferred Provider Plan

Your Preferred Provider Plan provides coverage for services provided by Preferred Provider Plan Network and Non-Preferred physicians and other professional providers as listed below. For assistance in locating a **Preferred Provider Plan Network** physician or provider please visit our Web site at www.or.regence.com.

Please note: This benefit summary provides a brief description of your health care plan benefits and is not a guarantee of payment. Please refer to your benefits booklet for a complete list of benefits and the limitations and exclusions that apply.

Benefit Features	Preferred Provider Benefit	Non-Preferred Provider Benefit
Lifetime maximum benefit	\$2,000,000	
Individual deductible per calendar year	\$200	
Maximum family deductible per calendar year	\$600	
We pay covered expenses up to this amount	\$5,000	
After \$5,000 in covered expenses each calendar year, we pay	100%	
Maximum amount of covered expenses you pay each calendar year per person (your maximum coinsurance)	\$500	\$1,000
Important note: Covered expenses paid at 100% and copayments do not accumulate toward your deductible or maximum coinsurance. Copayments will continue to be collected after your maximum coinsurance has been met.		
Preventive Care Services		
Deductible Waived - We Pay		
Immunizations all ages	100% after \$10 copay	100% after \$10 copay
Well-baby care	100%	100%
Annual women's exam including Pap test and mammogram	100%	100%
Routine physical exam including related lab and X-ray	100%	100%
Professional Services		
After Deductible - We Pay		
Office visits	90%	80%
Diagnostic radiology and lab	90%	80%
Therapeutic injections including allergy shots	90%	80%
Maternity care	90%	80%
Surgery	90%	80%
Hospital Services		
After Deductible - We Pay		
Inpatient stay including maternity, mental health, chemical dependency and rehabilitation	90%	80%
Outpatient surgery	90%	80%
Emergency room care (copay waived if admitted to hospital or other facility on an inpatient basis)	90% after \$100 copay	80% after \$100 copay
Other Services		
After Deductible - We Pay		
Ambulance	90%	80%
Rehabilitation including occupational, speech, and physical therapy	90%	80%
Skilled nursing facility, home health, and hospice care	90%	80%
Durable medical equipment and supplies	90%	80%
Additional Benefits and Information		
BlueCard® program	Provides savings nationwide by using physicians and other professional providers of the Blue Cross and/or Blue Shield Plan in the area where you receive the service. Using providers outside of the Blue Cross and/or Blue Shield Plan may likely result in greater out of pocket expenses. Find a provider near you at www.bcbs.com .	
myRegence.com	myRegence.com is designed to advise you on health care and lifestyle options, navigate you through the health care system, and reward you who make healthy choices. Go to www.myRegence.com and view claims; get fitness and nutrition tips; learn about medical conditions, medications and formulary information; search for doctors; and research cost and care options.	

See page 2 for limitations and exclusions >

Limitations and Exclusions

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Preventive Care Schedule

Immunizations (Not covered for travel or passport purposes)

All ages	As indicated by provider
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Well-baby care

Newborn	Nursery care including initial exam
First two years	7 well-baby exams

Women's exam

Annual breast & pelvic Mammograms	Every calendar year
Age 35-40	Once during this time
Age 40+	Every calendar year

Routine physical exam including related lab and X-ray*

Age 2-6	Every calendar year
Age 7-18	Every 2 calendar years
Age 19-34	Every 4 calendar years
Age 35+	Every 2 calendar years

*We pay up to \$100 for you or your enrolled spouse and up to \$35 for each of your enrolled dependent children

Prostate and Colorectal Cancer Screening

Covered services include medically necessary prostate and colorectal cancer screenings. Please refer to your benefits booklet for how cancer screenings are covered.

These Benefits Are Limited

- Residential care treatment for mental health conditions is limited to 45 days per calendar year per enrollee.
- Mental health treatment for parent-child relational problems, neglect or abuse of child, and bereavement is limited to children five years of age or younger.
- We provide transplant coverage only to those who have been covered by us, or another insurer with similar transplant coverage, for a total of at least 24 months (or since birth), providing there is no lapse between the two coverages. Benefits are based on the recipient's eligibility, not the donor's.
- Inpatient rehabilitation benefits are limited to 30 inpatient days per calendar year. Benefits are increased to 60 days per calendar year for head and spinal cord injuries or stroke. Neurodevelopmental therapy is limited to children age 17 and under.
- Outpatient rehabilitation benefits are limited to 30 sessions per calendar year. Benefits are increased to 60 sessions per calendar year for head and spinal cord injuries or stroke. Neurodevelopmental therapy is limited to children age 17 and under.
- Skilled Nursing Facility care is limited to 100 days per stay.
- Home health care is limited to 180 visits per calendar year.
- Dental care is limited to the treatment of an accidental injury to natural teeth or a fractured jaw. Diagnosis must be made within 6 months and treatment within 12 months of the injury.
- Ground ambulance is limited to 500 miles per calendar year.
- The following will be covered only after six months of enrollment: preexisting conditions, allergies, otitis media (ear infections), removal of tonsils and adenoids, elective and sterilization procedures. You may receive credit from prior medical coverage. See your benefits booklet or employer for details.

Emergency Care Guidelines

Covered services include the medical examination and ancillary tests required in determining the extent of an emergency medical condition. Examples include:

Suspected heart attack	Serious burn
Loss of consciousness	Poisoning
Bleeding that does not stop	Severe pain

Chemotherapy Prescription Medication Information

Covered services include medically necessary self-administered chemotherapy medications, including oral medications. Please refer to your benefits booklet for how prescription medications are covered.

Services And Supplies Not Covered

- Services provided by a member of the patient's immediate family.
- Charges in excess of the amount allowed according to the terms of the contract.
- Services or supplies that are not medically necessary.
- Services related to or supporting infertility and reversal of sterilization procedures.
- Orthognathic surgery.
- Custodial care, personal hygiene, and other forms of supervised self-care.
- Services and supplies provided for obesity or weight reduction, including complications arising from such treatment.
- Mental health treatment for conditions and diagnosis that describe relational problems, problems related to abuse or neglect or other issues that may be the focus of assessment or treatment. This would include, but is not limited to, such issues as occupational or academic problems.
- Services and supplies (including medications) for or in connection with sexual dysfunction regardless of cause, except for counseling services provided by covered, licensed mental health practitioners.
- Treatment, surgery, or counseling services for sexual reassignment.
- Mental health treatment for paraphilia for all age.
- Developmental learning disabilities for age 18 and older.
- Cosmetic/reconstructive services and supplies, including complications arising from such services.
- Experimental or investigational treatment, procedures, equipment, devices, and supplies.
- Treatment for addiction to tobacco, tobacco products, nicotine substitutes, or foods.
- Appliances or equipment primarily for personal comfort or convenience, and therapeutic devices including eyeglasses and hearing aids (except as specified in the benefits booklet).
- Routine physical, mental, eye, hearing examinations, or eye exercises (except where specifically listed).
- Surgery to alter the refractive character of the eye.
- Self-help training, instructional programs, and physical exercise programs (except where specifically listed).



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Regence BlueCross BlueShield of Oregon

Toll-free, all areas 1 (800) 228-0978

TDD Line for people with hearing impairments 1 (800) 382-1003

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